Primary Care Committee (PCC) Curriculum Renewal

Final Report

April 1, 2013

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1.0 Charge

The Primary Care Committee (PCC) of the curriculum renewal effort at the UWSOM was charged with the following:

- Critically assess curricular programs that currently work well in promoting and advancing primary care and those programs that either need improvement or should be terminated, including justification for any such recommendations.
- Recommend new programs and/or approaches that will advance the understanding, adoption and education in primary care among UW School of Medicine students, including justification for any such recommendations, while acknowledging the needs and demands of the additional areas identified as priorities within the School of Medicine curriculum renewal. This is to include assessment of the financial needs of programs and/or approaches and justification.

Committee Membership

The committee was chaired by Jay Erickson MD Family Medicine, Regional Clinical Assistant Dean, Montana; Alson Burke MD Obstetrics and Gynecology; Julie Calcavecchia UWSOM Colleges; Erin Cooley MS2; Laurel Desnick MD Internal Medicine, RUOP; Kellie Engle, Regional Affairs; Tom Greer MD MPH Family Medicine, TRUST; David Harrison MD Psychiatry, Systems of Human Behavior; Matt Hartman MS2; Lauren Hanson MS3, MPH candidate; Helen Melland RN PhD Dean College of Nursing Montana State University; Tom Nighswander MD MPH Family Medicine, Regional Clinical Assistant Dean, Alaska; Doug Paauw MD Internal Medicine, Clerkship Director; Alicia Quella PA PhD MEDEX Spokane; Anna Shope MD Obstetrics and Gynecology; Richard Shugerman MD Pediatrics, Residency Director; Kyle Yasuda MD Pediatrics, College Faculty.

2.0 Background

The PCC, comprised of students, junior faculty who are recent graduates of UWSOM, and leadership from Family Medicine, Internal Medicine and Pediatrics, met a total of seven times. The committee reviewed the Primary Care education literature, current UWSOM curriculum and extracurricular programs aimed at promoting Primary Care, and interviewed the following thought leaders to review their perspectives about Primary Care medical education:

- Kevin Grumbach MD, Professor and Chair of the Department of Family and Community Medicine at the University of California, San Francisco. Co-Director of the UCSF Center for Excellence in Primary Care, and Co-Director of the Community Engagement and Health Policy Program for the UCSF Clinical and Translational Science Institute.
- Howard K. Rabinowitz MD, Ellen M. and Dale W. Garber Professor of Family Medicine, and Professor of Pediatrics at Jefferson Medical College of Thomas Jefferson University. Since 1976, Director of Jefferson's Physician Shortage Area
Program, a special admissions and educational program that has been successful in increasing the supply and retention of family physicians in rural areas.

- Andrew Morris-Singer MD, President and Principal Founder of Primary Care Progress (PCP) an organization committed to advancing primary care at all levels. Since 2009, he has been an advocate for improved primary care programming at Harvard Medical School. Dr. Morris-Singer is a nationally known speaker on topics including strategic community engagement, clinical innovation, and direct action organizing in primary care. Dr. Morris-Singer is an instructor in Medicine at Harvard.

2.1 Factors Important to Primary Care Outside of the UMGE Curriculum at UWSOM

The PCC realizes that there are many factors affecting the declining Primary Care workforce regionally and nationwide. While the charge of the PCC was to address changes within the UGME curriculum at the UWSOM, the committee felt that the following eight considerations are extremely important to the overall improvement in the quantity and quality of primary care clinicians produced at the UWSOM. Two of the primary care thought leaders interviewed by the PCC described admissions and primary care reimbursement as the two most important factors in improving the outlook for the primary care workforce, followed by a thoughtfully designed UGME curriculum for Primary Care.

2.1.1 Definition of Primary Care

“Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

Primary care specialties comprise: Family Medicine, Internal Medicine and Pediatrics.

Primary Care: America’s Health in a New Era Molla S. Donaldson, Karl D. Yordy, Kathleen N. Lohr, and Neal A. Vanselow, Editors; Committee on the Future of Primary Care, Institute of Medicine. 1996

Four key features of primary care:

1. **It is person-focused rather than disease-focused.** This is defined by sustained relationships between patients and providers in primary care practices over time, often referred to as continuity.
2. **It provides a point of first contact for whatever people might consider a health or health care problem.** In properly organized health care systems, primary care ensures access to needed services.
3. **It is comprehensive.** By definition, it can encompass any problem. Ideally, primary care meets a large majority of patient needs without referral.
4. **It coordinates care.** Primary care adopts mechanisms that facilitate the transfer of information about health needs and health care over time and between settings. Highly personalized solutions to patients’ problems can be implemented when
sustained relationships permit deeper knowledge and understanding of individuals’ habits, preferences, goals and barriers.


2.1.2 Supply and Demand for Primary Care Clinicians

Wyoming, Montana, Idaho, and Alaska rank as some of the most rural states in the nation with 70%, 65%, 34%, 28% of the population living in rural counties as defined by county-level determinations of the U.S. Department of Agriculture using Rural-Urban Continuum Codes. In Washington State 12% of the population lives rurally. The majority of counties in the five WWAMI states meet federal criteria as health professions shortage areas. The number of active primary care physicians per capita varies widely across the region with much of the primary care clustered around urban and small city centers. Idaho, Wyoming, Montana, Washington and Alaska rank 48th, 40th, 30th, 15th and 12th respectively in number of active primary care physicians per capita.

Recent survey data confirm shortages in the health workforce in the WWAMI states both for specialists and generalists. The number of openings for generalists is roughly twice that for specialists. The shortages are likely to worsen as physicians retire, as the population ages and as health insurance coverage is expanded to a larger proportion of each state’s residents. The geriatric age group is also increasing at a disproportionately high rate in the rural areas characterizing much of the WWAMI region.

The proportion of the population in our region that is Hispanic, African-American, and Native American is also growing, with significant percentages uninsured. Physicians from these ethnic backgrounds are more likely to provide primary care services in underserved and minority communities and to care for both the uninsured and those on Medicaid.

UnitedHealth Group, Modernizing rural health care: coverage, quality and innovation, Analysis of county-level rural-urban codes from the Department of Agriculture and population data from the U.S. Census Bureau: Minnetonka, MN; Working Paper 6, 2011.

2004 UWSOM Primary Care Pipeline Committee

2.1.3 Pipeline

An adequately diverse pool of applicants to the UWSOM will be crucial if we are to continue to meet the primary care demands of our region. Pipeline programs like UDOC that encourage an ethnically, culturally, experientially and geographically diverse pool of applicants must be supported, along with AHECs and others in the region who partner with us to develop robust K-12 pipeline projects.
2.1.4 Admissions

The PCC reviewed past work by the School of Medicine regarding admissions practices that could positively influence our regional primary care workforce. The committee would like to highlight recommendations of the 2005 Admissions Review Committee especially in the following two areas:

**Prospective Class Description:** Based on our school’s mission and both the workforce needs and the demographics of our WWAMI region, we should prospectively determine the description of the class that is to be admitted, and the Admissions Committee should be instructed to admit a class that is most likely to meet and graduate to achieve this description. It is noted that this measure must be based on high quality current workforce data.

**Primary Care Track Study:** We recommend that a committee be appointed to study the establishment of a rural primary care track for students who are admitted, similar to our MSTP track for MD/PhD research scientists. A separate pool of seats could be set-aside for these candidates. The Physician Shortage Area Program (PSAP) at Jefferson Medical College may be an appropriate model for us to examine and perhaps emulate.

The PCC recognizes the critically important role that admissions plays in matriculating a student body with high potential to enter Primary Care careers. The curriculum renewal process is an opportune time to review and adapt current admissions policies to align more closely with the mission of the UWSOM.

The PCC recommends that the Admissions Committee adopt a goal that 50% of graduates will ultimately choose a Primary Care Practice in Family Medicine, Internal Medicine or Pediatrics, consistent with the recommendations of the 2004 UWSOM Primary Care Pipeline Committee.

*2005 UWSOM Admission Review Committee Final Report*

*2004 UWSOM Primary Care Pipeline Committee*

2.1.5 Medical Student Debt

Increasing medical student debt loads can turn students away from choosing Primary Care careers (Mean UWSOM debt 2012- $139,000). Consideration of novel scholarship, loan repayment, and service obligation associated loan forgiveness programs will be important in supporting UWSOM student choices of Primary Care careers without disproportionate financial hardship.
2.1.6 GME

The PCC recognizes the need for a wide variety of Primary Care GME opportunities available to graduates of the UWSOM to create an educational continuum within the WWAMI region. Opportunities for GME in all of the primary care specialties currently exist in Seattle but, not in the five state area. The 19 WWAMI Family Medicine Residency sites and recent efforts by the Departments of Psychiatry and Pediatrics to establish new primary care tracks in Alaska are encouraging trends. The PCC recommends that the School of Medicine bring together GME leaders in all of the primary care disciplines to explore new methods for collaboration in this vital area.

2.1.7 Primary Care Reimbursement

The issue of appropriate reimbursement of Primary Care physicians is a necessary component in our ability to encourage medical students to pursue careers in Primary Care. Changing reimbursement models also have the potential to support innovative practice models, like Patient Centered Medical Homes and Accountable Care Organizations; these may provide for more sustainable primary care practice environments and thus encourage an increase student interest in the field. The PCC recommends that the School of Medicine explore new ways to utilize the potential strength and momentum that the five state WWAMI partnership can provide nationally, regionally and on a statewide level in advocating to achieve these goals.

2.1.8 Measurement of true Primary Care output from the UWSOM.

The PCC recommends that the School of Medicine re-affirm its commitment to the 2004 UWSOM Primary Care Pipeline Committee report, setting a measurable goal of at least **50%** of the graduates of UWSOM entering Primary Care practice. Health systems focused on Primary Care have been found to be associated with more effective, equitable and efficient health services as well as obtaining better reported health outcomes at lower costs. This goal of **50%** into Primary Care would allow UWSOM to be accountable to the region that it serves. Current national figures for input into true primary care practice following residency are: Family Medicine 90%, Pediatrics 45% and Internal Medicine 22%. Based on 2013 match data the UWSOM will have a predicted 26% output into true Primary Care. UWSOM needs to regularly evaluate its success in meeting this 50% goal, and make appropriate changes in admissions and curriculum.


*Schwartz MD, The US Primary Care Workforce and Graduate Medical Education Policy, JAMA 2012; 308(21):2252-53.*

*2004 UWSOM Primary Care Pipeline Committee*

*COGME 20th Report, Advancing Primary Care 2010*
3.0 Key recommendations towards the future of Primary Care education at the UWSOM:

The UWSOM enjoys a national reputation of excellence in Primary Care education. To maintain leadership in this field we must continually reassess, seeking fresh and effective educational strategies to train the highest quality physicians. This report offers recommendations for a Primary Care Curriculum which supports the highest achievement for our students, faculty, and the communities we serve in the WWAMI region.

3.1.1 Primary Care Leadership and Management

The committee recommends an integrated leadership model that crosses departments and programs and fosters a shared sense of vision throughout the UWSOM and the region. This includes the development of a Vice Dean for Primary Care position to ensure the continued growth of our institution as a leader in the field of Primary Care education and research. Departments of Family Medicine, Internal Medicine and Pediatrics would be deeply involved, along with collaboration from other Departments at the UGME and GME level. This Primary Care leadership would also ensure adequate support for community practices involved in teaching the Primary Care curriculum.

Currently, the UWSOM lacks a unified vision of its commitment to excellence in Primary Care education. In 2013 the UWSOM dropped to the #2 ranked Primary Care Medical School after being ranked #1 for 19 years by US News and World Report. The curriculum renewal process offers the opportunity to bring departments, programs and faculty together to re-build our leadership in Primary Care education locally and nationally.

2004 UWSOM Primary Care Pipeline Committee

Best Grad Schools 2014 US News and World Report

3.1.2 Meaningful Clinical Experience in the Foundations Phase.

Thought leaders from across the country as well as our own UW medical students and faculty on the PCC recommend development of a meaningful clinical experience in the Foundations phase to teach key concepts of primary care to all students. Skilled clinician educators and highly functioning primary care settings are essential components of this type of experience. The current UWSOM curriculum has some existing programs that incorporate principles of the meaningful clinical experience such as TRUST, RUOP and preceptorships, though they may provide variable quality within and between programs. The new model would replace the current 1st and 2nd year preceptorships, while TRUST and RUOP would remain.

We envision an in-depth clinical experience at all six first year WWAMI sites (UW-Seattle, WSU-Spokane, University of Wyoming, University of Alaska, Montana State
University, University of Idaho/WSU-Pullman). It would begin early in year one and continue for the full length of the Foundations Phase. A multi-disciplinary team of primary care and specialty care clinician educators, behavioral health and public health professionals would teach medical students and other health professions students together for a four week immersion block at the start of the first year. The immersion experience would provide students the basic clinical tools to begin integrating patient care and professional role development with other material learned in the Foundations Phase.

Subsequent to the initial four weeks, students will participate in regular and consistent Primary Care clinical contact, either one day per week or one week out of six during the Foundations Phase. The clinical contact should be with the same Primary Care preceptor, with the option to switch preceptors at the halfway point to accommodate student interests in practice setting or patient population. Primary Care continuity and the ability to develop an ongoing relationship with patients, mentors and staff are vital to this experience.

The meaningful clinical experience will be based in a Primary Care outpatient setting that meets the standards for a highly functional outpatient health care system. A curriculum for academic credit will accompany this experience, and should include such topics as: team based care, patient centered care, population health, public health, leadership principles, enhanced communication skills, chronic care management, evidence based care, self-reflection and cultural competency. Students will also participate in a directed quality improvement or practice transformation project during the experience.

The RUOP program, including the Practicum Project in Population Health, should be incorporated into this experience either mid way or at the end of the Foundations Phase. Students would be placed at rural or urban underserved practices across the WWAMI region. This will expose students to different clinical settings and preceptors, and offer the opportunity to practice clinical skills learned throughout the Foundations Phase.

The meaningful clinical experience would be coordinated and supported by Academic Affairs to ensure optimal student placement, assessment, educational quality, consistency and faculty development.

http://depts.washington.edu/fammed/education/programs/ruop

http://depts.washington.edu/write/

http://depts.washington.edu/fammed/predoc/trust

3.1.3 Early Dynamic Primary Care Mentorship

Early dynamic Primary Care mentorship is integral to creating positive experiences in primary care, both in the meaningful clinical experience and Foundations course work. Relationship building with mentors in primary care specialties who exhibit mastery in clinical reasoning, self-reflection, understanding of community health and a commitment to life-long learning will foster interest in primary care as well as teach foundational concepts to those moving into other specialties. Ensuring the highest quality Primary Care mentors will be central to the success of the meaningful clinical experience curriculum.

Training and maintaining an outstanding cohort of master clinician educators for the region in all Primary Care specialties will be an essential role for UWSOM in the coming years. Innovative solutions to develop a cohort of appropriate clinician educators should include building partnerships to utilize senior UWSOM clinician educators, residents, residency faculty and others to shape student experience and strengthen skills of community primary care preceptors. Creating a culture of teaching among current students and residents will encourage careers in medical education, particularly in the WWAMI region.

Partnership with community Primary Care practices to enhance clinical care and provide support through this period of rapid transition toward new models of care will be especially important for the rural and remote areas of the WWAMI region.


3.1.4 Establish a Primary Care Track

Intentional training for students interested in Primary Care, similar to the MSTP training for MD-PhD researchers, is gaining support in U.S. medical schools. Currently the TRUST program trains students in a four-year longitudinal curriculum for rural and underserved practice in the region. TRUST could be expanded to include an urban underserved track. Additionally, a similar four year curriculum with focused admissions oriented toward general Primary Care practice is recommended. This Primary Care Track would enjoy resource allocation similar to a MSTP program.

Key aspects would include:

- Four year continuity mentoring
- Leadership training
- Participation in a Pathway (Underserved, Indian Health, Hispanic or Global Health)
- Focus on Community and Public Health with the possibility of a combined MD/MPH degree
- Completion of a research or population health project
- Link with Primary Care GME
- Offer a Master’s in Science pathway for qualifying students
• Integration of coursework with non-Primary Care pathway students to foster relationship-building between future colleagues
• Multiple entry points to ensure that the program is available to the largest number of students possible

UCSF Primary Care Leadership Academy

Warren Alpert Medical School of Brown University is developing a novel M.D./Sc.M. program in Primary Care and Population Health

Duke Primary Care Leadership Track

3.1.5 Longitudinal Integrated Clinical experience

Longitudinal Integrated Clinical (LIC) experiences are gaining recognition as an alternative model of UGME both in the US and internationally. A LIC experience allows students to complete the required clinical clerkships simultaneously and longitudinally in the Clinical Phase. In a sample week of a LIC experience, students may participate in all of the required clinical clerkships or at least a majority of the required clerkships. There is a growing body of evidence that LICs offer a variety of important changes in clinical education. This model has success both in urban academic centers (Harvard-Cambridge and UCSF-PISCES) as well as rural based models (Minnesota-RPAP and UWSOM-WRITE).

The transformative educational principles that LICs represent include: (1) educational continuity; (2) relationship-based education; (3) authentic roles in care; (4) upholding meaningful connections to medicine’s ideals such as service, advocacy, and patient centeredness; and (5) duty and commitment as drivers of learning.

The UWSOM currently has one program modeled after an LIC. WRITE, initiated in 1996, has enjoyed many successes focused around its roots as a rural workforce program. Historically the program has served 10-12 students yearly, with plans to increase to 24 in the 2013 academic year. The regional Track sites which currently host 35-50 students yearly could be adapted to serve as regionally based LICs in small urban settings (Boise, Spokane, Anchorage, Billings and Missoula). Placement of a LIC in the Seattle area would serve students wanting a more urban based experience. Continuing the existing LIC-WRITE and adapting some regional and Seattle-based Tracks will allow for the majority of the class to participate in a LIC during the clinical phase. Collaboration between all of the primary clinical disciplines within the School of Medicine will be essential to meet this important goal. Careful attention to teaching quality and consistency throughout the region will be essential to all LIC experiences.

3.1.6 Interprofessional Education

The importance of creating innovative team-based learning models with other health professional students should be emphasized in the medical school curriculum. The Patient Centered Medical Home concept emphasizes the delivery of primary care and prevention by multi-disciplinary led health care teams. Physician assistants, nurse practitioners, clinical pharmacists, social workers, and nurses would all be valuable partners in the educational and clinical setting.

The goal of an interprofessional primary care curriculum is to collaboratively educate health professional students to prepare them to work together to solve clinical problems. By training together, students can learn to manage complicated patients while developing essential communication and listening skills. Moreover, understanding the roles and abilities of other health professionals will ultimately improve patient care and outcomes. Students and faculty appear to enjoy team-based learning and many expect it to be a part of health profession training. Overall, health profession faculty need training and support from institutional leadership in order to become successful interprofessional educators.


Core Competencies for Inter-professional Collaborative Practice, Report of an Expert Panel, Inter-professional Education Collaborative 2011

3.1.7 Key primary care educational principles important for inclusion within all four years of UGME at UWSOM

A. Patient centered medical home (PCMH) principles

The Patient Centered Medical Home is a reality of patient care in 2013 and may become much more widespread in the foreseeable future. The PCMH provides comprehensive care in a health care setting that facilitates partnerships between individual patients, their personal care providers and the extended healthcare team. The PCC proposes that UWSOM students be exposed to the foundations of PCMH during the LCE in the Foundation phase, on a consistent basis through interprofessional programming, and then throughout the Patient Care and Career Exploration phases. To the extent possible, team care will be both taught and experienced as students actively participate in practices modeled on these principles and other payment reform strategies such as ACOs.

2007 Principles of the Patient Centered Medical Home - AAFP, ACP, AAP and AOA
B. **The importance of integrating public health and population health principles into UGME at all levels.**

The dramatic rise in health care costs has led many stakeholders to explore innovative ways of reducing costs and improving health. Research findings continue to clarify the importance of social and environmental determinants of health in chronic illnesses and the benefit of primary prevention for all people. An unprecedented wealth of health data is providing new means to understand and address health issues at the population level.

All graduates of UWSOM should understand the following core principles that intersect population health and primary care. These principles will be incorporated across all levels of the UGME curriculum.

- Health care systems should be focused on improving population health as well as caring for individual patients
- Social determinants of health must be understood in relation to chronic illness
- Health disparities disproportionately affect marginalized populations
- Community perspective is vital in defining and addressing health care needs
- Leadership is necessary to bridge disciplines, programs, and jurisdictions to improve population health
- Data and analysis should be used collaboratively to monitor results of population based interventions

*Primary Care and Public Health: Exploring Integration to Improve Population Health. IOM 2012*

C. **Embrace change toward an expanded system of values in medical education**

Issues brought forth by students, patients, and health advocacy organizations include social stewardship, promotion of well care rather than sick care, equity and justice, and health care economics. We must respond by expanding our priorities in these key areas of medical education.

- Awareness of economics and health care costs
- Continual pursuit of safety and quality in patient care
- Commitments to justice and equity in health care and health status
- Honest, transparent and respectful communication in all interactions within the health care system
- Teamwork and accountability of professionals to each other and to patients regardless of specialty

3.1.8 Support for Service Learning and Community Service

The values inherent in service are key values within Primary Care and all medical practice. All students, faculty and community preceptors should be supported in multiple service learning and community service activities.

There must be adequate time in the curriculum for students to participate in and initiate service learning and community service experiences throughout the region. Administrative support for such efforts should be a continued focus at UWSOM to allow for sustainability, and long term development of appropriate projects.


http://www.uwmedicine.org/Education/MC-Program/Current-Students/student-affairs/Student-Groups/Interest-Groups/Pages/default.aspx

http://depts.washington.edu/fammed/education/programs/fmig

http://www.uwmedicine.org/Education/MC-Program/Current-Students/student-affairs/Student-Groups/Interest-Groups/Pages/PediatricInterestGroup.aspx

http://students.washington.edu/osleruw/Osler_Club/Welcome.html

3.1.9 Social Accountability of Medical Schools

The PCC committee recognizes the importance of the Social Accountability of Medical Schools based upon the World Health Organization’s concept of “social accountability: “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.”

The WAMI program initiated in 1971 was a partnership in regional medical education designed to increase the number of generalist physicians in the region. Currently, the mission statement of the UWSOM, in collaboration with the WWAMI states, describes a social responsibility to provide care and improve the health status of the communities we serve. Our continued focus on educating outstanding primary care physicians is an important step in supporting this mission through education, research and clinical excellence.